## Medical Certificate (to be completed by the doctor)

**Must be returned to the addressee within a reasonable time.**

ADDRESSEE
**ADESIO Assurances asbl**
**Chaussée de Marche 604 – 501 Erpent**
General: 078/150154
Email : sinistre@adesio.be

SURNAME AND FIRST NAME OF VICTIM: .....

DATE OF ACCIDENT: ..... CLAIM REF: .....

School: .....

Policy no.: .....

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|---|---|
| Date, time and place of the first examination | |
| VERY COMPLETE DIAGNOSIS OF THE AILMENT<br>Objective signs: (indicate very precisely the type, nature and severity of the injuries and the parts of the body affected) | |
| SUBJECTIVE symptoms complained of by the injured party | |
| Date and origin of the injuries according to the injured party | |
| According to the objective findings, is the origin stated by the injured party and the date indicated by him/her likely or unlikely? If unlikely, on what findings did you base your decision? | |
| Can the injured party continue to work full time or part time? If not, on what dates should he/she stop work? | |
| Approximately how long will the treatment last? | |
| PROGNOSIS: A- Full recovery<br>B- Total or partial permanent disablement<br>C- Death | |
| Is there nothing that the injured party is suffering from that could normally aggravate the consequences of the accident? Previous illnesses: | |
| Is constant treatment given? Where and by whom? | |
| Do you consider it appropriate for the injured party to be referred to another doctor (specialist, surgeon, radiologist etc) and why? | |
| Do you think it in the interests of the injured party or the company to have the victim hospitalised? Why? | |
| Special comments: | |

Drawn up in……..on ……..20… Signature of doctor

Name and address or stamp of the doctor